		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026955

Facility Name: Washington Christian Village

Address: 1110 New Castle Road (Number) Washington (City) 61571 (Zip Code)

County: Tazwell

Telephone Number: 309-444-3161 **Fax #** ( )

IDPA ID Number: 37-0841562006

Date of Initial License for Current Owners: 4/01/82

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501©3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2001 to June 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark Havrilka

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) William O. Buskirk, CPA

(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624

(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,535	6,549	1,835	20,919	8
9	SNF/PED					9
10	ICF	6,542	12,111		18,653	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,077	18,660	1,835	39,572	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.87%

D. How many bed-hold days during this year were paid by Public Aid?
288 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/01/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 21 and days of care provided 7,665

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Washington Christian Village # 0026955 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	182,350	18,557	7,989	208,896		208,896		208,896			1
2	Food Purchase		184,777		184,777		184,777	(2,287)	182,490			2
3	Housekeeping	105,648	15,897		121,545		121,545		121,545			3
4	Laundry	61,950	14,363		76,313		76,313		76,313			4
5	Heat and Other Utilities			101,567	101,567		101,567	4,084	105,651			5
6	Maintenance	74,227	31,795	24,038	130,060		130,060	6,885	136,945			6
7	Other (specify):*											7
8	**TOTAL General Services**	424,175	265,389	133,594	823,158		823,158	8,682	831,840			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	1,903,715	189,535	205,996	2,299,246		2,299,246		2,299,246			10
10a	Therapy			153,798	153,798		153,798		153,798			10a
11	Activities	28,913			28,913		28,913	351	29,264			11
12	Social Services	112,726	1,418	3,207	117,351		117,351		117,351			12
13	Nurse Aide Training											13
14	Program Transportation			2,451	2,451		2,451	(4,296)	(1,845)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,045,354	190,953	372,052	2,608,359		2,608,359	(3,945)	2,604,414			16
	C. General Administration											
17	Administrative	106,830	1,660	176,172	284,662		284,662	(118,660)	166,002			17
18	Directors Fees											18
19	Professional Services			17,548	17,548		17,548	12,906	30,454			19
20	Dues, Fees, Subscriptions & Promotions			30,732	30,732		30,732	(7,385)	23,347			20
21	Clerical & General Office Expenses	70,359	5,933	45,277	121,569		121,569	52,703	174,272			21
22	Employee Benefits & Payroll Taxes			410,010	410,010		410,010	21,001	431,011			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,705	11,705		11,705	5,992	17,697			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,652	63,652		63,652	2,506	66,158			26
27	Other (specify):*											27
28	**TOTAL General Administration**	177,189	7,593	755,096	939,878		939,878	(30,937)	908,941			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,646,718	463,935	1,260,742	4,371,395		4,371,395	(26,200)	4,345,195			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington Christian Village #0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			119,068	119,068	(3,667)	115,401	8,283	123,684			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			325,818	325,818		325,818	(6,384)	319,434			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,167	1,167		1,167		1,167			36
37	**TOTAL Ownership**			446,053	446,053	(3,667)	442,386	1,899	444,285			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	16,769	798		17,567		17,567		17,567			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* Apt/Congregate			115,982	115,982	3,667	119,649	(16,430)	103,219			43
44	**TOTAL Special Cost Centers**	16,769	798	182,777	200,344	3,667	204,011	(16,430)	187,581			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,663,487	464,733	1,889,572	5,017,792		5,017,792	(40,731)	4,977,061			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,690)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(18,893)	32		10
11	Discounts, Allowances, Rebates & Refunds	280	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(16,430)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,296)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,000)	21		24
25	Fund Raising, Advertising and Promotional	(7,385)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	12,427			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,987)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,256		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,256		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (40,731)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Washington Christian Village

ID# 0026955

Report Period Beginning: July 1, 2001

Ending: June 30, 2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Expense	$ (836)	17	1
2	Vending Machine Expense	403	2	2
3	Activity Revenue	351	11	3
4	PY Deferred Bond Cost Expense	12,509	32	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	12,427		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,287)	0	0	0	0	0	0	0	0	0	0	(2,287)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,084	0	0	0	0	0	0	0	0	0	4,084	5
6	Maintenance	0	6,885	0	0	0	0	0	0	0	0	0	6,885	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,287)	10,969	0	0	0	0	0	0	0	0	0	8,682	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	351	0	0	0	0	0	0	0	0	0	0	351	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(4,296)	0	0	0	0	0	0	0	0	0	0	(4,296)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,945)	0	0	0	0	0	0	0	0	0	0	(3,945)	16
	C. General Administration													
17	Administrative	(836)	(117,824)	0	0	0	0	0	0	0	0	0	(118,660)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,906	0	0	0	0	0	0	0	0	0	12,906	19
20	Fees, Subscriptions & Promotions	(7,385)	0	0	0	0	0	0	0	0	0	0	(7,385)	20
21	Clerical & General Office Expenses	(8,720)	61,423	0	0	0	0	0	0	0	0	0	52,703	21
22	Employee Benefits & Payroll Taxes	0	21,001	0	0	0	0	0	0	0	0	0	21,001	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,992	0	0	0	0	0	0	0	0	0	5,992	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,506	0	0	0	0	0	0	0	0	0	2,506	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(16,941)	(13,996)	0	0	0	0	0	0	0	0	0	(30,937)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,173)	(3,027)	0	0	0	0	0	0	0	0	0	(26,200)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Washington Christian Village** **#** **0026955** **Report Period Beginning:** **July 1, 2001** **Ending:** **June 30, 2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	8,283	0	0	0	0	0	0	0	0	0	8,283	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,384)	0	0	0	0	0	0	0	0	0	0	(6,384)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,384)	8,283	0	0	0	0	0	0	0	0	0	1,899	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(16,430)	0	0	0	0	0	0	0	0	0	0	(16,430)	43
44	**TOTAL Special Cost Centers**	(16,430)	0	0	0	0	0	0	0	0	0	0	(16,430)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(45,987)	5,256	0	0	0	0	0	0	0	0	0	(40,731)	45

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc	100.00%	$ 4,084	$ 4,084	1
2	V	6	Maintenance				6,885	6,885	2
3	V	17	Administrative	176,172			58,348	(117,824)	3
4	V	18	Directors						4
5	V	19	Professional Services				12,906	12,906	5
6	V	20	Fees, Subscriptions						6
7	V	21	Clerical				61,423	61,423	7
8	V	22	Employee Benefits				21,001	21,001	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				5,992	5,992	10
11	V	26	Insurance				2,506	2,506	11
12	V	30	Depreciation				8,283	8,283	12
13	V								13
14	Total			$ 176,172			$ 181,428	$ * 5,256	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Revenue Bond 2001-Y (92%)	x		Refinance debt	$13,416.00	10/01/01	$ 2,301,544	$ 2,301,544	10/01/31	0.0700	$ 120,829	1
2	Refinanced mort & bonds	x	x	Redeem Debt	-0-			-0-			28,089	2
3	Tax Exempt Bonds		x	Bldg & Equipment	$6,883.33	09/01/91	1,000,000	665,000	09/01/11	0.0600	41,100	3
4	Revenue Bonds 1996-A	x		Redeem Debt	$3,867.67	07/01/96	500,000	453,833	07/01/21	0.0700	32,028	4
5	Revolving Loan Fund	x		Roof Work - Bldg.	$552.08	11/01/96		55,185	03/01/96	0.0200	1,163	5
	Working Capital											
6	CHI Bond Fund	x		Operations	$5,000.00	Various	Various	550,863	09/01/19	0.0850	35,206	6
7	Revenue Bond 1999-A	x		Redeem Debt	$6,739.00	01/01/99	1,000,000	941,800	01/01/24	0.0700	64,055	7
8	Financeing fee amort										3,348	8
9	TOTAL Facility Related				$36,458.08		$ 4,801,544	$ 4,968,225			$ 325,818	9
	B. Non-Facility Related*											
10	Refinanced bonds	x		Redeem Debt				-0-			4,378	10
11	Revenue Bonds 2001-Y (8%)	x		Redeem Debt	$1,167.00	10/01/01	198,456	198,456	10/01/31	0.0700	10,421	11
12	Refinanced mortgage		x	Redeem Debt				-0-			1,629	12
13												13
14	TOTAL Non-Facility Related				$1,167.00		$ 198,456	$ 198,456			$ 16,428	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 5,166,681			$ 342,246	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-02-14-300-023	SEC 14 T26N R3W	$ 1,627.90	$
2.	02-02-14-300-021	SEC 14 T26N R3W	$ 13,527.80	$
3.	02-02-14-308-001	SEC 14 T26N R3W	$ 6,207.82	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,363.52	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,484 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	38,484	1982	$ 50,000	1
2	Home Office Allocation			8,009	2
3	TOTALS	38,484		$ 58,009	3

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122		1982		$ 1,203,052	$ 34,373	35	$ 34,373	$	$ 696,916	4
5											5
6											6
7											7
8	Home Office Allocation				57,269	1,677		1,677		28,170	8
	Improvement Type**										
9	Heating Control System			1982	14,940	622	20	622		14,940	9
10	Office Door			1982	299	9	35	9		181	10
11	Heating Control System			1982	28,554	1,422	20	1,422		28,554	11
12	A/C Compressor			1982	1,200		5			1,200	12
13	Improvements			1982	13,562	387	35	387		7,547	13
14	Improvements			1983	34,486	985	35	985		18,961	14
15	Sprinkler System			1983	1,806	72	25	72		1,392	15
16	A/C Condensors			1983	4,775	239	20	239		4,522	16
17	Boiler			1983	8,332	417	20	417		7,818	17
18	Water Heater			1983	321		15			321	18
19	Sign			1984	2,800		12			2,800	19
20	Door			1984	231	7	20	7		128	20
21	Nurse Call System			1984	2,930		15			2,930	21
22	Alarm System			1984	786	39	20	39		692	22
23	Remodeling			1985	18,956	542	35	542		9,485	23
24	Tub Room			1985	1,230		15			1,230	24
25	Insulation			1985	4,890	245	20	245		4,145	25
26											26
27	Light Fixtures			1985	425		10			425	27
28											28
29											29
30	Ceiling Tile			1985	323	16	20	16		272	30
31	Roof repairs			1985	342,609	9,789	35	9,789		171,307	31
32	Fire door			1986	400	20	20	20		328	32
33	Insulation			1986	4,203	210	20	210		3,290	33
34	Energy Management system			1987	2,691		10			2,691	34
35	Decorations			1988	342		5			342	35
36	Wall coverings			1988	356		5			356	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Improvements	1988	$ 3,706	$ 106	35	$ 106	$	$ 1,511	37
38	Duct Work	1988	313		10			313	38
39	Painting(Remodeling)	1988	886		5			886	39
40	Wallpaper	1988	910		5			910	40
41	Nurse Call System	1989	8,534	569	15	569		7,539	41
42	22 Overbed lights	1989	1,579		10			1,579	42
43	Bath station	1989	558	37	15	37		487	43
44	Floor coverings	1990	1,765		5			1,765	44
45	Relay Stone and Tuckwork	1991	2,395	120	20	120		1,350	45
46	Remodel nurses station	1991	6,026	402	15	402		4,523	46
47	Water Heater	1991	1,223	54	10	54		1,223	47
48	Gutter & Soffit	1992	9,161	611	15	611		6,110	48
49	Water Heater	1993	1,134	113	10	113		1,045	49
50	Boiler	1993	11,405	760	15	760		6,523	50
51	Fire System-Horn/Strobe	1994	1,560	156	10	156		1,300	51
52	Water Heater	1994	890	89	10	89		734	52
53	Main/Store Room Doors	1994	1,730	173	10	173		1,355	53
54	Electrical Outlets	1994	813	81	10	81		634	54
55									55
56	HW Enthalpy Controls	1994	1,097		5			1,097	56
57	Doors	1995	3,368	337	10	337		2,499	57
58	Cabinets SFF Dining	1995	2,189	146	15	146		1,046	58
59	Hot H20 Lines/Rerout	1995	7,345		5			7,345	59
60	Rubber Adhered Roof	1996	62,678	3,134	20	3,134		20,110	60
61	BTC 200 Water Heater	1996	2,384	238	10	238		1,527	61
62	Kitchen Door	1996	622	62	10	62		393	62
63	Exhaust Fan/Light	1996	918	92	10	92		560	63
64	Add 4 baseboard heaters	1996	1,100	110	10	110		633	64
65	Wallpaper	1996	2,417	163	5	163		2,417	65
66	Remodel foyer area	1996	17,101	1,710	10	1,710		9,547	66
67	Carpeting - Front Entry	1997	974	195	5	195		926	67
68	Roof Work - North Wing	1997	32,480	2,165	15	2,165		10,103	68
69	IDPH Construction Project fee	1997	910	91	10	91		273	69
70	TOTAL (lines 4 thru 69)		$ 1,941,939	$ 62,785		$ 62,785	$	$ 1,109,206	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,941,939	$ 62,785		$ 62,785	$	$ 1,109,206	1
2	Wallpaper SW alcove	1998	1,030	206	5	206		893	2
3	Replace cove base	1999	2,009	201	10	201		787	3
4	100 gal. Gas water heater	1999	2,358	236	10	236		905	4
5	Kitchen fire suppression system	1999	1,307	131	10	131		469	5
6	Wallpaper office conference room	1999	2,148	430	5	430		1,362	6
7	Condensing unit	1999	875	88	10	88		271	7
8	Wallpaper office alcove	1999	1,894	379	5	379		1,169	8
9	Carpeting offices	1999	3,510	702	5	702		2,164	9
10	Chaplain's Office A/C Unit	2000	875	88	10	88		220	10
11	Smoke Detectors (3)	2000	544	54	10	54		158	11
12	Boiler	2000	5,250	263	20	263		548	12
13	Automatic Opener Front Doors	2000	5,204	520	10	520		867	13
14	Airphone Emergency Phone System	2001	2,005	201	10	201		285	14
15	Remodeling South Wing	2001	47,029	3,135	15	3,135		3,919	15
16	Carpet E/W Corridors & Volunteer Ofc	10/1/2001	2,419	363	5	363		363	16
17	Remodeling South Wing	9/1/2001	1,755	98	15	98		98	17
18	Upgrades to Boiler System	11/1/2001	19,857	1,324	10	1,324		1,324	18
19	(3) Steel Doors	12/24/2001	1,371	80	10	80		80	19
20	Modular Nurses Station	5/24/2002	4,744	79	10	79		79	20
21	Opto 22 - Heating/AC Control System	1/8/2002	15,227	381	20	381		381	21
22	Architects Fees/Remodeling of Building	6/1/2002	11,383	63	15	63		63	22
23	Remodeling	4/30/2002	93,076	1,551	15	1,551		1,551	23
24	Remodel Front Entrance	4/24/2002	840	14	15	14		14	24
25	Remodel North Corridor/Wall Coverings	5/1/2002	66,545	2,218	5	2,218		2,218	25
26	Remodel North Corridor/Carpet	4/30/2002	27,270	1,364	5	1,364		1,364	26
27	Remodel North Corridor/Cove Base Hand Rail	4/30/2002	20,507	342	15	342		342	27
28	Replace A/C in Lobby	4/25/2002	2,276	57	10	57		57	28
29	Carpet/New Offices Near Lunch Room	5/1/2002	560	19	5	19		19	29
30	Corridor Door	4/30/2002	743	19	10	19		19	30
31	Remodel New Offices Near Lunch Room	5/1/2002	1,319	22	10	22		22	31
32	Carpet/Kitchen, Storage Rm, Back Ofc & H	6/21/2002	6,262	104	5	104		104	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,294,131	$ 77,517		$ 77,517	$	$ 1,131,321	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,294,131	$ 77,517		$ 77,517	$	$ 1,131,321	1
2									2
3									3
4									4
5									5
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7									7
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,294,131	$ 77,517		$ 77,517	$	$ 1,131,321	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 268,306	$ 30,045	$ 30,045	$	Various	$ 156,112	71
72	Current Year Purchases	84,292	3,969	3,969		Various	3,969	72
73	Fully Depreciated Assets	160,580				Various	160,580	73
74	Home Office Allocation	87,083	3,772	3,772			47,318	74
75	TOTALS	$ 600,261	$ 37,786	$ 37,786	$		$ 367,979	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1995 Ford Bus	1995	$ 44,381	$ 5,548	$ 5,548	$	8	$ 41,610	76
77										77
78	Home Office Allocation			10,260	2,833	2,833			7,173	78
79										79
80	TOTALS			$ 54,641	$ 8,381	$ 8,381	$		$ 48,783	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,007,042	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,684	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,684	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,548,083	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 170,656	$	$	86
87	Land Improvements	83,628	4,269	66,531	87
88	Apartments & Equipment	655,886	22,867	372,491	88
89	Out Buildings	7,869	787	4,609	89
90					90
91	TOTALS	$ 918,039	$ 27,923	$ 443,631	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This Workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	Workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	Applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Washington Christian Village **#** 0026955 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 32,256	$	1
2	Cash-Patient Deposits	13,407		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,791)	439,022		3
4	Supply Inventory (priced at FIFO)	22,089		4
5	Short-Term Investments	12,644		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	1,014		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 520,432	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	2,880,942		14
15	Leasehold Improvements, at Historical Cost	83,628		15
16	Equipment, at Historical Cost	577,228		16
17	Accumulated Depreciation (book methods)	(1,909,053)		17
18	Deferred Charges	10,695		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	249,194		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,063,290	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,583,722	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 86,815	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,407		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,430		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,045		32
33	Accrued Interest Payable	3,325		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposit Payable	1,470		36
37	Revolving Fund	55,185		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 417,677	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,111,496		41
42	Deferred Compensation	110,164		42
	Other Long-Term Liabilities(specify):			
43	Apt/Resident Security Deposit	83,816		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,305,476	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,723,153	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,139,431)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,583,722	$	48

***(See instructions.)**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,693,882)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,693,882)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(673,040)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **PY Deferred Bond Cost Expense**	(12,509)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (685,549)	17
	B. Transfers (Itemize):		
18	**Transfer In from Affiliate**	240,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 240,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,139,431)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,255,018	1
2	Discounts and Allowances for all Levels	(1,400,540)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,854,478	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	248,541	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 248,541	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(753)	12
13	Barber and Beauty Care	22,846	13
14	Non-Patient Meals	2,690	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,483	19
20	Radiology and X-Ray	398	20
21	Other Medical Services	763	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,427	23
	D. Non-Operating Revenue		
24	Contributions	21,782	24
25	Interest and Other Investment Income***	22,203	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 43,985	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	1,660	27
28	Residential & Congregate	167,661	28
28a	Unrealized G(L) on Investments/Sale of Assets		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 169,321	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,344,752	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	823,158	31
32	Health Care	2,608,359	32
33	General Administration	939,878	33
	B. Capital Expense		
34	Ownership	446,053	34
	C. Ancillary Expense		
35	Special Cost Centers	133,549	35
36	Provider Participation Fee	66,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,017,792	40
41	**Income before Income Taxes (line 30 minus line 40)****	(673,040)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (673,040)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,355	$ 52,620	$ 22.34	1
2	Assistant Director of Nursing	1,711	2,040	40,216	19.71	2
3	Registered Nurses	14,783	18,155	432,178	23.80	3
4	Licensed Practical Nurses	16,838	19,223	359,298	18.69	4
5	Nurse Aides & Orderlies	77,406	82,772	989,901	11.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,560	2,727	29,502	10.82	8
9	Activity Director	1,645	1,744	20,239	11.60	9
10	Activity Assistants	928	971	8,674	8.93	10
11	Social Service Workers	8,627	9,181	112,726	12.28	11
12	Dietician					12
13	Food Service Supervisor	1,770	1,931	26,441	13.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,410	17,361	155,909	8.98	15
16	Dishwashers					16
17	Maintenance Workers	5,655	5,857	74,227	12.67	17
18	Housekeepers	10,529	11,131	105,648	9.49	18
19	Laundry	7,076	7,358	61,950	8.42	19
20	Administrator	2,085	2,801	106,830	38.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,765	1,956	28,144	14.39	23
24	Clerical	1,928	2,214	42,215	19.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,304	1,328	16,769	12.63	33
34	TOTAL (lines 1 - 33)	174,964	191,105	$ 2,663,487 *	$ 13.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	231	$ 7,989	1.3	35
36	Medical Director	36	6,600	9.3	36
37	Medical Records Consultant	20	640	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	150	4,180	10.3	39
40	Physical Therapy Consultant	1,713	77,787	10A.3	40
41	Occupational Therapy Consultant	1,450	68,259	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	129	7,752	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	58	3,207	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,787	$ 176,414		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James M Robinson	Administrator	0	$ 106,830
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,830

B. Administrative - Other

Description	Amount
Management Expense	$ 176,172
TOTAL (agree to Schedule V, line 17, col. 3)	$ 176,172
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 7,719
SAK Management	Consulting	8,677
The Finn Group	Consulting	1,000
FR & R Consulting	Medicare Consulting	152
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,548

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,732
Unemployment Compensation Insurance	6,000
FICA Taxes	196,932
Employee Health Insurance	88,900
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	34,512
Employee Physicals	4,849
WC Medical Expense	85
Home Office Allocation	21,001
TOTAL (agree to Schedule V, line 22, col.8)	$ 431,011

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,552
Health Care Worker Background Check	
(Indicate # of checks performed)	
Software Updates & Support	6,324
Online, Remote, & Media Fees	827
Life Services Network Dues	5,605
Dues & Subscriptions	1,604
Miscellaneous Fees	435
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,347

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,313
Seminar Expense	4,447
Other	1,945
Home Office Allocation	5,992
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,697

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2001 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **Life Services Network - $5,605**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,613** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,795**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,690**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **No**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **To be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Washington Christian Village
Summary of Payroll Benefits

kdb
10/27/02

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Insurance	Benefits	Employee Expense	Physicals	WC Med Expense	
140,841.64	3,960.00	51,960.00	60,550.00	75,204.79				
13,535.78	600.00	7,944.00	7,700.00	4,985.18				check
8,556.91	420.00	5,304.00	700.00	5,087.17				517,586.78
3,802.05	180.00	2,424.00	2,100.00	547.00				
5,628.80	168.00	2,244.00	4,200.00	3,386.52				
10,160.88	372.00	4,872.00	8,050.00	5,035.16				
13,169.38	252.00	3,288.00	5,600.00	13,326.74	34,511.88	4,849.00	85.00	
1,240.90	48.00	696.00	0.00	0.00				
196,936.34	6,000.00	78,732.00	88,900.00	107,572.56	34,511.88	4,849.00	85.00	517,586.78

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Less: Benefits -107,572.56

410,014.22